The development of William Reid and Laura Epstein’s task-centered model is embedded in the empirical clinical practice movement in the United States, which intended to place social work practice on a scientific basis. This chapter focuses first on the larger empirical practice history and then on the development of task-centered practice within that context.

**Empirical Clinical Practice in the United States**

Twentieth-century efforts to make social work scientific include legitimating research as a source of data for intervention knowledge, providing evidence on the outcomes of social work practice, building...
empirical practice models like the task-centered model, and acceptance of evidence-based interventions and decision making.

ESTABLISHING THE RELEVANCE OF A SCIENTIFIC APPROACH

Beginning with Mary Richmond (1917), social work writers attempted to structure intervention with systematic, rational decision making based on empirical knowledge (Kirk & Reid 2002; Reid, 1994). Shortly after World War II, as specialist social work groups began talking about joining forces, researchers organized to define their roles and contributions to social work (Graham, Al-Krenawi, & Bradshaw, 2000).

The Social Work Research Group (SWRG) was founded in 1949. In 1955 it was one of seven professional groups that formed the National Association of Social Work (NASW). From 1963 to 1974 SWRG was a council within NASW, then in a reorganization of NASW, research lost its independent status and recognition. SWRG’s substantial accomplishments over its 25 years included defining social work research; integrating research into the role and curricula of schools; disseminating research results through conferences, a newsletter, and the first database of social work research, Social Work Abstracts; and improving capacity through workshops and publication of the first social work research textbook: Norman A. Polansky’s 1960 Social Work Research (Graham et al., 2000; Kirk & Reid, 2002). By the early 1970s, social workers recognized the value of a scientific approach but did not integrate it with social work practice.

RESEARCH ON SOCIAL CASEWORK

During the same period—the 1950s to the 1970s—social work researchers conducted numerous ambitious, large-scale social experiments. These studies for the first time assumed that there were measurable outcomes of practice and that it was desirable to study those outcomes. Subjects included intensive individual psychodynamic services for predelinquent boys (the Cambridge-Somerville study) (Powers & Witmer, 1951); services for mentally impaired older persons in need of protective services (the Benjamin Rose study in Cleveland) (Blenkner, Bloom & Nielsen, 1971); psychodynamic services for families receiving public assistance (the Chemung County, New York, study) (Wallace, 1967); and family-centered casework for multiproblem families (Geismar & Krisberg, 1967). Together, the studies examined work with a cross-section of social work clientele: predelinquent and delinquent boys; girls on probation; bright, disadvantaged minority youth; high school girls; new AFDC recipients; longer-term multiproblem families; and older individuals. The interventions
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were predominantly psychodynamic approaches, individual and group services, and help with environmental resources.

The outcomes of these social experiments were not encouraging. Several reviews suggested that social work intervention was ineffective or even detrimental (Mullen & Dumpson, 1972; Fischer, 1973). For example, predelinquent youth were as likely to follow criminal careers if they received services (Powers & Witmer, 1951), while older individuals who received intensive social work services died more often than those who did not (Blenkner et al., 1971). These unwanted results spurred two efforts: an age of accountability during which practitioner-researchers attempted to infuse practice with evaluation and measurable outcomes, and a reexamination of the principles of casework, including rethinking psychodynamic approaches and looking to new strategies such as task-centered, cognitive-behavioral, and systems approaches (Kirk & Reid, 2002).

BEGINNINGS OF EMPIRICAL PRACTICE

One approach to the challenge posed by poor outcomes of casework intervention was to further integrate a scientific approach into practice. Intervention models could be built using research, and intervention could include research procedures. The broadest definition of scientific practice was from Reid and Audrey Smith, who wrote that scientifically based or empirical practice includes five elements: empirical language in which key terms can be tied to measurable indicators; use of well-explicated practice models that link interventions and change; priority placed on research-based knowledge as a means of assessment and selecting interventions; use of scientific reasoning, rather than intuition or faith, to make decisions; and use of research methods as an integral part of practice (Reid & Smith, 1981). These assumptions about practice were a response to the interest in effective practice but also a direct challenge to the prevailing psychodynamic and functional interventions.

The new ideas about empirical practice were developed initially at the Columbia University School of Social Work doctoral program in the late 1950s and early 1960s. The context of scientific skepticism and dissatisfaction with psychodynamic casework stimulated a cohort of doctoral students who would become leading proponents of scientific practice (Kirk & Reid, 2002; Reid, 1994). After graduation, they clustered at five schools: University of California, Los Angeles, University of Washington, University of Michigan, University of Wisconsin–Madison, and University of Chicago. At each, they established systematic research programs to improve social work interventions.

Columbia graduate Scott Briar championed the “clinician scientist” and practitioner contribution to intervention knowledge through single-system designs (Blythe, Tripodi, & Briar, 1995). Edward J. Mullen
worked on practitioners’ individualized models of evidence-based practice, a precursor to the current evidence-based practice (EBP) (Mullen, 1978). Several clusters of faculty and their graduate students refined behavioral group and individual interventions in cumulative research programs. These included Edwin J. Thomas and Sheldon Rose (Michigan graduates), Elsie Pinkston (a University of Kansas psychology graduate), and Columbia graduates Richard Stuart, Tony Tripodi, Irwin Epstein, and Arthur Schwartz (Thomas, 1974; Rose, 1980; Pinkston, Levet, Green, Linsk, & Rzepnicki, 1982; Stuart, 1977; Schwartz & Goldiamond, 1975; Tripodi & Epstein, 1980; Ivanoff, Blythe, & Tripodi, 1994). Reid and Laura Epstein (a Chicago graduate) developed a new practice approach—the task-centered model—which is based not on behavioral methods but on the results of research on psychodynamic practice (Reid & Epstein, 1972).

These faculty and their students shared a commitment to developing practice through empirical means. All were prolific writers who attempted to integrate their research results and theoretical foundations into new formulations of social work practice that challenged the prevailing psychodynamic interpretations. Their research models focused on intervention; they evaluated change, rather than conducting explanatory research to establish the cause of a problem. They influenced each other and in turn influenced scores of students to continue the development of empirical practice and research on interventions.

While the proponents of empirical practice focused on developmental research, social work intervention theories blossomed as scholars developed models that integrated new ideas from various sources. These nonempirical models included several versions of the generalist model (Compton & Galaway, 1975; Pincus & Minahan, 1973); the life model (Germain & Gitterman, 1980); and general systems (Goldstein, 1973), family systems (Hartman & Laird, 1983), and ecosystems theory (Meyer, 1976). Although these nonempirical models dominated in education and practice (for example, U.S. accreditation standards required generalist practice), gradually the empirical and nonempirical models influenced each other. For example, behavioral (learning) theory and cognitive theory were integrated in cognitive-behavioral theory, task-centered practice incorporated systems theories, and generalist practice included notions of client determination and contracts.

EVIDENCE-BASED INTERVENTIONS

Outside of social work, intervention research was linked primarily to specific problems, rather than models with multiple applications. Interventions were eclectic or nontheoretical. For example, what is now called the National Institutes of Health is organized by area: aging,
mental health, drug abuse, and so on. When the federal government agreed to bolster the research infrastructure for social work (on the basis of recommendations in the 1988 NIMH Task Force on Social Work Research; see National Institute of Mental Health, 1991), funding for intervention research was based on problems, not on the theoretical or empirical models developed within social work. Each of the eight research centers that were established focused on a specific area of mental health, as did the research methodology workshops for faculty (Austin, 1999). In 2009, the directory of federally funded grants maintained by the Institute for Advancement of Social Work Research (IASWR, 2009) displayed the specific, focused, and problem-oriented nature of federally funded social work research: grantees focused, for example, on adherence to a low-fat diet, motivational enhancement for drug addicts, treatment of depression among older alcoholics, reduction of HIV risk among drug users, and so on.

Most of the research on social work practice since 1988 has been problem-specific. Because the eclectic interventions in recent research are usually based on best-known practice, the favored interventions are those already supported by evidence—including structured interventions, cognitive-behavioral methods, group interventions, and primary prevention (Reid & Fortune, 2003). As a consequence, there are multiple evidence-supported interventions for narrowly defined problems, while many of the popular social work interventions have not been tested.

A related development in empirical practice was the study of how social workers make decisions about interventions. Many of the Columbia University pioneers had been influenced by James Bieri, who studied clinical decision making (Reid, 1994). Mullen’s (1978) personal practice model was a form of decision making using research evidence. Aaron Rosen and Enola K. Proctor (1978) studied clinician decision making from several perspectives. Eventually they developed and tested a structured decision-making system called systematic planned practice and specified the necessary components of practice guidelines (Rosen, 1993; Proctor & Rosen, 2003).

In the mid 1980s, Leonard Gibbs began advocating better reasoning in clinical practice and preparing curricular materials to teach critical thinking (1985, 2003). Gibbs joined Eileen Gambrill (a graduate of Edwin J. Thomas’s Michigan program and an ardent behaviorist) to promote critical thinking in the United States (Gambrill, 1990, 1993). Their model was heavily influenced by David Sackett’s evidence-based medicine (Sackett, Richardson, & Haynes, 1997), adopted in 1991 by the United Kingdom Health Service, which includes social workers. The Gambrill-Gibbs model involves a seven-step process: 1) being motivated to use EBP; 2) defining an answerable practice question; 3) finding the best available evidence to answer the question; 4) assessing the evidence; 5)
integrating the evidence with practice experience, client values, and other relevant factors; 6) implementing and evaluating the intervention; and 7) teaching others (Gibbs, 2003; Gibbs & Gambrill, 1999).

The concurrent developments in problem-based research and critical, rational decision making in the 1980s and 1990s allowed the two to be melded into the EBP decision-making process. Evidence-supported interventions from problem-based research could be retrieved, evaluated, and implemented using the EBP decision-making process. The difficulty, of course, is that the supply of well-validated, evidence-supported interventions is much slimmer in social work than medicine, and the criteria for validation are controversial. For clients with multiple, varied problems, the array of evidence-based guidelines is overwhelming and may not be appropriate for comorbidity. To make the evidence-supported interventions more accessible to practitioners, several organizations assess research in a particular area and summarize the findings. Notable are the Cochrane Collaboration in medicine, founded in 1993, and the Campbell Collaboration for education, criminal justice, and social welfare, founded in 2000. In the United States, rich sources of evidence-supported interventions are available at the National Association of Social Work, the National Institutes of Health, the U.S. Department of Health and Human Services, and many other organizations.

In 2008, the Council on Social Work Education (CSWE) mandated that evidence-based interventions be included in the curricula of U.S. schools of social work (CSWE, 2008). CSWE’s accreditation standards did not define evidence-based intervention, and there is considerable ambiguity about its meaning. However, Danya International developed a social work EBP curriculum funded by the National Institutes of Health. Collaborators included six social work organizations, including CSWE, and many scholars of EBP, including Mullen and Proctor (Danya International, 2008). The Danya curriculum—called REACH-SW—views EBP as a process to retrieve information and evaluate research evidence. If it is widely adopted, EBP as a decision-making model will be the standard for empirical practice in U.S. social work education. Given the limitations on available valid interventions and on practitioner time to retrieve them, it is likely that EBP decision making will be reintegrated with broader empirical models that provide a framework and practice skills for making sense of EBP.

The Task-Centered Model

Task-centered casework was developed at the University of Chicago School of Social Service Administration by faculty members Reid and
Laura Epstein and their students. Reid was a graduate of the Columbia University doctoral program that influenced so many social work researchers. Epstein was an experienced psychodynamic practitioner, a master’s graduate of Chicago, a field educator, and a social work practice teacher. They began developing the task-centered model in 1968 and continued the development through research until their deaths.

THE CATALYST FOR A NEW MODEL

The catalyst for the task-centered model was a study of casework with families who had problems in family relations. In 1965, after six years as a practitioner and five years as an academic, Reid became director of the Center for Social Casework Research at the Community Service Society of New York (CSS). There, he teamed with Ann W. Shyne (a founder of SWRG) to conduct a federally funded four-year field experiment comparing the effectiveness of several types of casework (Reid & Shyne, 1969). The study included 120 intact lower-middle-class families who had applied for services at CSS. Three comparisons of conventional and innovative forms of treatment were planned.

The primary interest was in testing two forms of psychodynamic intervention: ego-modifying casework and ego-supportive casework (Reid & Shyne, 1969). Ego-modifying casework requires advanced skill from the caseworker and is intended to develop insight to change the relationship between the client’s ego, id, and superego. Ego-supportive casework is intended to support the client’s extant ego functioning. The distinction was central to CSS’s developing practice theory and research. The two forms of casework were distinguished by the type of verbal interventions:

Both supportive and modifying methods were to be directed toward improvement in the client’s social functioning and his ability to cope with problems. The supportive method was to attain this end through use of reassurance, advice, and logical discussion of problems in the client’s current life situation, without a deliberate aim of increasing his self-understanding or of effecting other internal change. The modifying method, on the other hand, was to utilize techniques that encouraged self-examination by the client so that he might be helped to achieve better social functioning through increased understanding of himself and the dynamics and origin of his behavior. (Reid & Shyne, 1969, 20)

The second comparison of interest involved a relatively new development in casework: interviews with multiple clients simultaneously.
Family members were assigned to be interviewed individually (mothers, for the most part) or jointly (husband and wife).

The third comparison was between continuous, open-ended service—the standard procedure—and planned, short-term treatment. In open-ended service, “neither the recipient nor the practitioner is given any predetermined limits as to amount of input or duration” (Reid & Shyne, 1969, 5). Generally, practitioners expected open-ended treatment to be lengthy—and in this study, a third of the open-ended clients had thirty or more interviews. In planned, short-term service, clients were informed that service would be no longer than eight in-person interviews within three months of intake.

The families were randomly assigned to one of eight groups that each received a different combination of psychosocial interventions (a 2 x 2 factorial experiment). For example, families in one group received ego-supportive casework with individual interviews in a planned, short-term format. Families in another group received ego-supportive casework with individual interviews in continuous, open-ended service. A third group received ego-modifying casework in individual interviews in a planned, short-term format, and so on. Thus, the design permitted examining each comparison while the other two comparisons were controlled.

The results of the experiment were complex, with some interesting nuances. For example, husbands participated more in planned, short-term treatment. Overall, however, the results were startling (and probably disappointing) to the researchers. For the first comparison—ego-modifying versus ego-supportive casework—analysis of audio tapings revealed no differences in practitioners’ use of techniques, regardless of which intervention was prescribed (Mullen, 1968; Reid & Shyne, 1969). Regardless of prescription, practitioners used mostly ego-supportive verbal interventions and almost no core modifying techniques that might develop insight or intrapsychic understanding. Thus an important theoretical distinction was not borne out in practice. (The study illustrates the importance of fidelity checks on intervention!)

In the second comparison—individual versus joint interviews—implementation was also difficult. While there were more joint interviews when joint interviews were prescribed, most were in short-term service. In open-ended service, practitioners usually lapsed to their accustomed individual interviews with mothers. There were no differences in outcome between families with joint interviews and those without, even when joint interviews were successfully implemented.

The final comparison was properly implemented. Families assigned to open-ended service received nearly four times as many interviews; the median number was more than twice as many interviews as in planned, short-term service; and one family received one hundred
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interviews. With all the additional service, however, families in open-ended service did not have better outcomes than the short-term service recipients. In fact, families in planned, short-term service did better in overall problem situation and on nine of thirty-two outcomes. The outcome measures included caseworker assessments, husband and wife reports, and reports from independent research judges. Most differences were at moderate levels of change, with small numbers of both groups rated as considerably changed, but more open-ended cases rated as unchanged or worse.

These surprising and unwanted results were similar to those from other contemporary studies of social work intervention. Differential interventions based on theoretically inspired distinctions could not be implemented. It was difficult (though not impossible) to get practitioners to change their individually oriented interviewing habits, but it did not make a difference when they did. Most startling was the equivalence or superiority of planned, short-term service. Reid and Shyne devoted much of their analysis to what might be the reason for the difference. Clearly planned, short-term service was not simply a matter of having fewer interviews of the same kind as in open-ended service. Instead, planned, short-term service seemed to evoke different dynamics, motivation, and levels of work from both practitioners and clients.

THE NEW TASK-CENTERED CASEWORK APPROACH

Reid and Shyne’s 1969 study served as a catalyst for developing a new treatment model based on what evidence suggested about effective treatment. Having returned to the University of Chicago in 1968, Reid recruited faculty colleague Laura Epstein, and together they developed and began teaching a new planned, short-term model based on psychosocial theory and research.

Reid and Epstein’s new model, initially called task-centered casework, incorporated some elements from the brief treatment in the Reid and Shyne study. These elements included a planned, short duration with time limits set at the beginning, a focus on client problems rather than a change in personality, and limited therapeutic goals directly related to the focal problems (Reid & Epstein, 1972). It differed from the earlier casework in that diagnosis was around problems and how to alleviate them (not on personality traits or ego functioning); specific, limited goals were set; and more attention was given to the client’s concept of problems and how to deal with them. Additional features, not related to the Reid and Shyne results, were a problem typology, explicit worker-client agreement or contracting, and the specification that change would occur through action, or tasks, rather than solely through
verbal support and insight. In-session interventions focused on developing and evaluating tasks that might resolve the clients’ problems and that the clients could undertake in their own environments.

Reid and Epstein drew extensively on the work of contemporary casework theorists in developing the task-centered model. The idea of a psychosocial problem (a target problem, or problem-in-living) as the focus of diagnosis and change was drawn from the work of Helen Harris Perlman (Perlman 1957), as were procedures for exploring problems. From Florence Hollis (1964, 1967a, 1967b), Reid and Epstein drew the practitioner’s verbal interventions during sessions (the same types of interventions that defined ego-modifying and ego-supportive casework in the Reid and Shyne study). From Ruth Smalley’s (1967) functional casework they drew the deliberate use of time, structure, and focus in casework, as well as client self-direction in using help. And from Howard Parad’s (1963) and Lydia Rapoport’s (1970) formulations of crisis theory, they drew the idea that problems-in-living could be resolved quickly.

The new task-centered model was an eclectic mix of theories and research results. It emphasized client preferences and client action in the environment, limited changes in problems in daily living, planned time limits, a well-defined structure for sessions, and an empirical orientation. The model was controversial, especially because it accorded less importance to the client-practitioner relationship as medium of change. Other key criticisms were that it involved inadequate assessment or diagnosis, which precluded gathering sufficient information for effective intervention; that the duration was too short for important or durable change; that interventions were too superficial to produce lasting change (which requires personality change); that clients were not able to know the best goals for themselves; and that it was impossible to measure goals and outcome.

These criticisms were rooted in the psychodynamic paradigm that Reid and Epstein challenged. Indeed, one of their direct challenges to prevailing theory—and this became a direct contribution to empirical practice—was that one need not get at underlying causes in order to change a problem. In both practice and intervention research, it was acceptable to focus on initiating and sustaining change without understanding or caring about the cause. Despite the criticisms, most practitioners could find some aspect of the task-centered model that was similar to what they were already doing, and this familiarity tempered some of the perceptions of how radical the model was.

An added benefit of the task-centered approach for inexperienced practitioners was that the steps in conducting sessions were laid out according to the phase of treatment. The initial phase focused on problem exploration, contracting around goals and time limits, and development of initial tasks. The middle (and longest) phase focused on results
of tasks, progress toward goals, and development of additional tasks through problem-solving steps that were later labeled task planning and implementation (TPIS). The terminal stage (one or two sessions) involved a review of the current status of problems and of problem-solving strategies, and establishment of plans for maintaining gains or tackling incompletely resolved problems. Figure 1 outlines the phases as they were elaborated in 1992 (Reid, 1992). The initial model was not complete, but it did include the basic phases and the task planning processes.

Reid and Epstein began empirical testing and development of their new model immediately. Their first book included reports of three small studies of thirty-two cases in medical social services and psychiatric outpatient services (Reid & Epstein, 1972). The results suggested that the model was useful, but they also led to a number of modifications in the model: more attention was given to the practitioner’s role and to how to develop tasks, estimate time limits realistically, handle new problems, and so on. For these trials, Reid and Epstein also devised measures of intermediate outcome (task accomplishment) and ultimate outcome (problem resolution) that continue to be used to assess client progress and the research-practice tools that Reid saw as part of empirical practice.

After publication of the first book on task-centered practice, Reid, the researcher, published more research while Epstein, the practitioner, concentrated on placing task-centered practice squarely in the context of social work and social work education. Epstein’s Helping people (1980), for example, gave a brilliant portrait of social work, public and private social services, and the growth of the public social welfare system, as well as the task-centered model. It was a popular introductory social work and counseling text that she revised three times, with the final, 4th edition, coauthored with Lester B. Brown and titled Brief treatment and a new look at the task-centered approach (2001). She also wrote another book, Talking and listening, which positioned the task-centered model in the microskills counseling approach (Epstein, 1985).

The Design and Development Process for New Interventions

The design and development (D&D) process for developing new interventions, as described by Jack Rothman and Edwin J. Thomas (Thomas, 1984; Rothman, 1980), consists of six steps: problem analysis and project planning, information gathering and synthesis, design, early development and pilot testing, evaluation and advanced development, and
FIGURE 1 Outline of Task-Centered Procedures by Phases

I. Initial Phase (Sessions 1–2)
   1. Discussion of reasons for referral, especially with nonvoluntary client(s)
   2. Exploration and assessment of client-acknowledged target problems and their contexts
   3. Formation of the service contract, including problems and goals to be addressed, explanation of treatment methods, agreement on durational limits
   4. Development and implementation of initial external tasks (see II-5 and 6, below)

II. Middle Phase
   (Each session follows the format below.)
   1. Problem and task review
   2. Identification and resolution of (actual) obstacles
   3. Problem focusing
   4. Session tasks (if two or more clients in session)
   5. Planning external tasks
      a. Generating task possibilities
      b. Establishing motivation
      c. Planning implementation of task(s)
      d. Identifying and resolving (anticipated) obstacles
      e. Guided practice, rehearsal
      f. Task agreement
      g. Summarizing task plan
   6. Implementation of task(s) (between sessions)

III. Terminal Phase (final session)
   1. Review of target problems and overall problem situation
   2. Identification of successful problem-solving strategies used by client(s)
   3. Discussion of what can be done about remaining problems, making use of strategies identified in II, above


Dissemination (Thomas & Rothman, 1994). (For a contemporary elaboration, see Fraser, Richman, Galinsky, & Day, 2009.) Reid and Epstein began their developmental research before D&D was well articulated, but in later publications they were explicit that D&D was the process they used (Reid, 1987a, 1994).

After the early development and pilot testing reported in Task-centered casework, Reid and Epstein began a series of randomized
experiments to evaluate the model. The first experiment looked at the effectiveness of planning tasks (Reid, 1975), the second at the task-centered process as a whole (Reid, 1978). These evaluations, like much of the later development of the model, engaged student-practitioners in Reid and Epstein’s practice classes at the University of Chicago (and later at the University at Albany, State University of New York).

As the model was disseminated, the research spread to doctoral students, community practitioners, and educators at other sites. For example, three large, carefully evaluated experiments were conducted in Britain: on social services, on probation, and on self-poisoners (Goldberg, Gibbons, & Sinclair, 1985). Even after the task-centered model was well accepted, its proponents returned to the initial steps of D&D when approaching a new use of the model (see, for example, Caspi, 2008).

VERBAL INTERVENTIONS, TASK PLANNING AND IMPLEMENTATION, AND TASK STRATEGIES

One component of the developmental research on the task-centered model focused on the mechanisms for change: verbal interventions, task planning, and strategies for using tasks with specific problems.

Given Reid’s experience working with Hollis and Shyne, researchers had questions about practitioners’ verbal intervention techniques: Were they similar to those in other types of casework? Were they related to outcome? Several studies suggested that task-centered practitioners made less use of exploration, but that exploration continued throughout the course of task-centered casework and was not restricted to the problem-formulation phase (Fortune, 1979a; Reid, 1978; Goldberg et al., 1985). Task-centered practitioners structured treatment more and gave advice more than subjects of previous studies of psychosocial casework (Reid, 1978), and they talked more (Fortune, 1979a). Among adult clients, but not child clients, greater use of advice and explanation about the client’s behavior was associated with better outcomes. In short, it appeared that practitioners in the task-centered model were more active, kept the clients focused on the matters at hand, and were more willing to offer advice (Fortune, 1979a).

On the basis of this and other research (Fortune, 1981; Davis, 1975; Ewalt & Kutz, 1976), Reid concluded that advice giving—a no-no in psychosocial casework—had a catalytic function. Clients did not always carry out the practitioner’s advice, but the advice stimulated their own successful ideas about how to accomplish tasks or resolve problems (Reid & Shapiro, 1969).

Reid soon added a second way to categorize verbal interventions, one based on the task-centered model’s problem-solving structure
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(Reid, 1978). Again, studies suggested that problem specification continued throughout treatment, as the practitioner and client explored new aspects of problems in order to develop tasks (Fortune, 1979b; Goldberg et al., 1985; Reid, 1978). About a fifth of intervention-phase interviews were devoted to task planning generally (Reid, 1978; Fortune, 1979b). Predominant task-planning activities were generating alternatives to problem resolution, analyzing obstacles to task accomplishment, establishing incentives and rationales for doing tasks, and review of previous tasks. The more time spent on target problems and tasks, the greater the resolution of client problems (Blizinsky & Reid, 1980).

Once it was established that task accomplishment (an intermediate outcome) was associated with problem resolution and improved overall situation (the ultimate outcome) (Goldberg et al., 1985; Reid, 1978), model developers concentrated on improving the task-planning process. The initial task-implementation sequence was expanded to include TPIS, with more attention to how the tasks would be done rather than just what the tasks were (Reid, 1978). Family systems theory was incorporated into assessment and task planning with families, especially in relation to communication and interaction patterns (Reid, 1985). Some tasks were dual-level meta-interventions designed to resolve a problem while also strengthening parental or sibling bonds. The family problem-solving sequence involved paired tasks, one completed in the session (for example, a discussion of conflict resolution between parent and child) and one completed at home after the session (Reid, 1987a). Evaluation suggested that shared tasks, done together, were more effective than individual tasks or reciprocal tasks (you clean your room, I’ll make your favorite dinner). These family practice developments led to reconceptualization of tasks as interventions both within and outside of sessions (Reid, 1985, 1987a, 1987b, 1992).

In the late 1980s and early 1990s, Reid’s D&D turned from the practitioners’ and clients’ in-session activities to the broader context of which strategies (that is, clusters or sequences of tasks) were more effective with particular problems. In an early work, The task-centered system, Reid (1978) included several types of task strategies, including incremental strategies—“a series of tasks of progressive difficulty . . . to help the client gradually achieve his performance goal” (pp. 147–148); interference in escalating sequences of action or interaction; and Haley’s (1976) paradoxical tasks and two-sided tasks. He also borrowed eclectically from programs in behavioral and other literature.

Beginning with Task strategies: An empirical approach to clinical social work, Reid presented strategies that were specific to particular problems and showed “in detail how an approach can be varied according to the problem for which the client is being seen” (Reid, 1992, p. 13). These strategies included sequences of tasks to deal with target
problems related to family problems, coping with stress, increasing social involvement, problem drinking, chronic mental illness, health problems, inadequate resources, and self-monitoring of depression. He also offered task strategies for resolving obstacles such as poor motivation, distorted beliefs, and lack of skill to complete a task. The task planner (Reid, 2000) is a compendium of specific target problems—such as alcoholism, elder abuse, withdrawal in children, and gambling—and recommended task strategies for each. Each entry includes a description, a menu of client and practitioner tasks, suggested roles for the practitioner, elaborations or helpful hints, and suggestions for further reading. Many of the entries were developed by Reid’s students and community practitioners. The book and its accompanying searchable CD are essentially a database of evidence-based and best practices for client actions that could resolve specific problems within a relatively short time.

When Reid and Epstein first described task-centered casework, they called it a general model that assumed that “certain fundamental principles can be successfully applied to a broad range of situations. . . . A practitioner need not master a large assortment of approaches to cope with the variety of cases . . . but rather can rely on variations of a single approach” (1972, p. 8). Their early D&D focused on the fundamental principles (client determination, action, TPIS, and so on), while later D&D with task strategies became more and more problem-specific and specialized. This development paralleled the problem-oriented focus of federally funded research and the EBP model in the late 1980s. The task-centered model became a curious amalgam of general and problem-specific intervention models. The principles, basic structure, and basic interventions (TPIS) were general, but the task strategies could be specific and were eclectic.

OTHER RESULTS OF D&D WITH THE TASK-CENTERED MODEL

The description of verbal, task planning and implementation, and task strategies interventions illustrates the D&D process for developing an intervention model over twenty-five years. At the same time, other developmental research refined other phases of the model and broadened the scope of the problems and populations with which the task-centered model was used. Problem specification became more sophisticated in response to overeager students, multiproblem families and involuntary clients (Rooney, 1992, 2009; Tolson, Reid, & Garvin, 1994; Trotter, 2006). Problems were placed in a larger context, and changing the context became a legitimate goal (Reid, 1996). Analyzing and overcoming obstacles to task accomplishment became a much more prominent part of the model (Reid, 1992). Unlike other problem-solving
approaches, the task-centered model included a technology “for assessing what goes wrong when well-planned goals go awry” (Rooney, 2010). The ending phase was elaborated to include interventions focused not on change but on generalizing and maintaining clients’ gains, such as reinforcement of accomplishments, planning to avoid future obstacles, and reviewing problem-solving skills (Brown, 1980; Fortune 1985; Tolson et al., 1994).

Most of the task-centered research was on intervention with individuals, children, adolescents, adults, elderly people, and families (especially those with child-related problems). Interventions were expanded to treatment groups whose members share similar problems and used task-centered structure and buddies or partners so clients could help each other develop and implement tasks (Fortune, 1985; Garvin, 1974; Rooney, 1977). Variations included case management with school children, their teachers, and their parents (Colvin, Lee, Magnano, & Smith, 2008a, 2008b; Vigianni, Reid, & Bailey-Dempsey, 2002); teams with teachers of disturbed students (Magnano, 2009); and case management with frail elderly people (Naleppa & Reid, 2003). In addition, proponents applied a task-centered framework to agency administration (Parihar, 1984), to community practice (Ramakrishnan, Balgopal, & Pettys, 1994), and to supervision of students (Caspi & Reid, 2002). Others integrated task-centered practice into generalist practice—multilevel, multisystems intervention—or melded it with basic social work skills (Epstein, 1980, 1985, 1988; Hepworth, Rooney, Rooney, Strom-Gottfried, & Larsen, 2010; Tolson et al., 1994).

Task-centered practice is the basis of social services in three countries—England, the Netherlands, and Norway (Marsh, 2010; Trotter, 2010; Eriksen, 2010)—and is used on its own or as a component of social work intervention in eleven other countries in Europe, Australia, and Asia. By 2010, there were over 200 publications on the task-centered approach in at least nine languages, including original textbooks in Great Britain, the Netherlands, and Norway (Doel & Marsh, 1992; Eriksen, 1999; Eriksen & Norstrand, 1995; Marsh & Doel, 2005; Jagt & Jagt, 1990; Jagt, 2001, 2008). Although few social work practitioners today identify themselves specifically or exclusively as task-centered practitioners, most make substantial use of components introduced by Reid and Epstein (Kelly, 2008).

The Contribution to Social Work Practice and Research

The task-centered model was created at a critical juncture in social work practice, when concern about the effectiveness of interventions coincided with a willingness to consider new ideas. The task-centered
Development of the Task-Centered Model

The development of the task-centered model was a product of that moment, and it also hastened the shift to new practice paradigms.

First, the task-centered model helped break the hold of psychodynamic casework on the practice community, opening the way for other means of conceptualizing psychosocial problems and their resolution. In the 1960s, psychodynamic approaches were dominant and went largely unquestioned except in the case of behavior modification, which was then new and controversial in social work. The task-centered model offered an alternative or intermediate approach that was more acceptable to psychodynamic practitioners than operant-respondent behavior modification. Reid and Epstein (1972) incorporated many ideas from psychosocial casework, which made task-centered practice palatable to many practitioners. They also had a means of validating their ideas through research. The ideas that the practice community eventually accepted included planned, short-term treatment; goal setting and contracting; action orientation (doing something about the problems, not just talking about causes); problem solving; and involving family members and other stakeholders in treatment. All of these concepts are now integral parts of "good social work" (Kelly, 2008).

A second contribution of the model was the integration of research and practice (Videka & Blackburn, 2010). The task-centered model included all five of Reid and Smith’s (1981) elements of empirical practice: empirical language, well-explicated links between interventions and change, research-based knowledge for assessment and intervention, scientific reasoning, and research methods as an integral part of practice. In the task-centered model, assessment was based on data from the client; interventions were developed by client and practitioner on the basis of that data, external research evidence (for example, from task planners) and the client’s desires; and task accomplishment and goal achievement were measured systematically. Practice and research methods were so well integrated that many neophytes were not aware of a distinction between them.

The task-centered model shared some of the research methods characteristic of Briar’s behavioral clinician–scientist model (Blythe & Briar, 1985; Ivanoff, Blythe, & Briar, 1987), such as measurable problems and data-based assessment. However, the task-centered model was not wedded to the single-system research approach that was a core of the clinician-scientist model. Thus Reid and Epstein were able to draw on multiple research paradigms in their D&D, which may have enhanced their credibility and certainly allowed them to evaluate multiple dimensions of the model.

In addition to demonstrating that a practice model could incorporate research methods without becoming rigid or onerous for the practitioner, the model also demonstrated the benefits of D&D. The task-centered model was not the only practice model developed through the
use of Thomas and Rothman’s (1994) development procedures, but it was a prominent example that was unusual for the long-term persistence of the development work. Many of today’s problem-specific intervention models are no longer evaluated after the initial round of D&D, so they are vulnerable to being inappropriate for new clients or settings.

A third contribution to social work practice was the conceptualization of intervention processes (TPIS) as interchangeable pieces that could be subject to research. Interventions were conceptualized as something different from simply time in interviews, as they were in the 1950s and 1960s research, and as something different from Hollis’s (1967a, 1967b) verbal interventions. The reconceptualization of intervention opened the possibility of mechanisms of change that were not solely psychodynamic. At the same time, behaviorists were elaborating single-system research designs that attempted to isolate key therapeutic elements through the study of intervention interactions, differential intensities of treatment, additive effects of bundled interventions, and “stripping” (removing) pieces of bundled interventions (Hersen & Barlow, 1976).

However, research on TPIS went farther: it assumed that the intervention mechanisms might work similarly for different clients. That is, although the substantive content of a task strategy depended on the client, the process of planning and elaborating tasks was similar among clients. This was the first assumption evaluated by Reid and Epstein, who found that clients who engaged in more task planning were more successful (Reid, 1975, 1978; Blizinsky & Reid, 1980). By conceptualizing interventions as interchangeable and researchable, Reid and Epstein contributed to the current formulations of intervention research.

A fourth contribution of the task-centered model was to field education in social work education. The task-centered courses and practica were a robust forerunner of what are now called “evidence-based practica.” For social work students at Chicago, field practica were linked directly to practice courses. While students learned intervention approaches, they implemented them in field agencies linked to the class section. In Reid and Epstein’s classes, the students served as practitioners in the developmental research, implementing the task-centered model according to protocols designed to test various aspects of the model. They also participated as clinician-scientists, evaluating their cases according to the research methods incorporated in the task-centered model (that is, measuring task accomplishment and goal achievement). In addition, they were research assistants, interviewing other students’ clients for outcome studies and analyzing small sets of data.

Beginning in the 1990s, students (and clients and community practitioners) developed task planners in specific areas of their own interest.
Thus research was a normative part of students’ clinical experience. This model of education in EBP is broader than the current model, in which the practitioner is viewed as an information retriever and critical thinker. It should be evaluated to see if it has more durable effects on practitioners’ incorporation of EBP than other models.

A side contribution of this field research environment was a re-conceptualization of process recordings as a conceptual learning tool. Traditional process recordings were verbatim transcripts of client-practitioner interactions, with commentary added by the student and field instructor. Process recordings were intended to help students conceptualize the process of what they were doing (Wilson, 1980). However, they focused on neither the conceptual framework of intervention, nor the skills needed to accomplish change, Epstein (1980) developed lists of skills that students needed to employ at each step of the task-centered process—for example, end-phase skills such as assessing change, discussing feelings about termination, and reviewing problem-solving skills. The skills were later elaborated by Eleanor Tolson (Tolson 1985; Tolson et al., 1994). Instead of writing verbatim re-creations of sessions, students of the task-centered model recorded case material on a form organized by components of the model (contract, goals, task review, task planning, and so on). These recording guides helped students conceptualize their practice within the task-centered framework.

At the same time, field instructors could identify and evaluate students’ skills quickly. The combination of conceptual recording guide and skills definition and assessment enabled students to learn skills more quickly and to become creative in their use of skills (Tolson, 1985). The specific skills also permitted comparison of various ways to evaluate students (Reid, Bailey-Dempsey, & Viggiani, 1996). Although task-centered recording guides were not unique, they were one of social work’s first consistent attempts to define and measure competencies for practice. They helped the social work education community accept that process recordings could include a wide variety of analytical tools for conceptual and skill learning (Graybeal & Ruff, 1995).

Summary

By the 1960s, social work scholars had accepted the credibility of research to evaluate and inform social interventions and were stymied by evidence of poor outcomes with then-dominant psychosocial casework. The dilemma catalyzed movements to develop new models of social intervention. One group of new approaches—behavioral, cognitive-behavioral, and task-centered practice—had empirical bases.
and were developed using research methods. The behavioral and later cognitive-behavioral approaches imported theory, practice, and research methodology from psychology and adapted them to social problems. The task-centered model was a homegrown social work model. Reid and Epstein drew from psychodynamic theory and from social work’s own research findings and then used D&D research to improve and validate the model over more than 30 years.

In 2008, Michael Kelly concluded, “many of the central principles of TCP are now considered simply good social work practice. . . . Its major contribution to the field of social work practice [may be] a sturdy yet flexible practice technology that contains enough rigor to be consistently effective but also enough space to be adapted creatively to an incredible number of social work practice contexts” (2008, p. 199). In addition to creating a new model, Reid and Epstein and their colleagues helped open all of social work to nonpsychodynamic approaches, they integrated research and practice in multiple ways, they reconceptualized intervention (not just outcomes) as researchable, and they integrated field education and empirical practice.

References


